New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A004	A. BUILDING: ______ B. WING ______	C **08/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE STANWICK ROAD	**301 N STANWICK ROAD** **MOORESTOWN, NJ 08057**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00166512 CENSUS: 82 SAMPLE SIZE: 4 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 765	8:36-7.4(c)(1) Resident Assessments and Care Plans (c) Written policies and procedures shall be developed and implemented to ensure, but not be limited to, the following: 1. Assessment of all residents with a general service plan at least semi-annually, and those residents who have a health service plan shall be reassessed at least quarterly and more often on an as needed basis, including and upon the resident's return to the facility from the hospital;	A 765		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE　　TITLE　　(X6) DATE

New Jersey Department of Health

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A 765	Continued From page 1 This REQUIREMENT is not met as evidenced by: Complaint: NJ00166512 Based on interview and record review it was determined that the facility's Registered Nurse (RN) failed to reassess the resident's condition upon return from the hospital for 1 of 4 residents, Resident #2. This deficient practice was evidenced by the following: Resident #2's medical record revealed that the resident moved into the facility on NJ ex order 26.4b1 with diagnoses NJ ex order 26.4b1 "Pre-Admission Medical Certification For Assisted Living" dated NJ ex order 26.4b1 completed by Resident #2's medical provider revealed that Resident #2 NJ ex order 26.4b1 . On 8/22/2023 at 2:30 p.m., the surveyor reviewed the facility document titled "Progress Notes" (PN) which revealed that Resident #2 NJ ex order 26.4b1 . The facility failed to prodive documented evidence that Resident #2 had been reassessed by an RN upon his/her return from the hospital. The PN also revealed that on NJ ex order 26.4b1, Resident #2 NJ ex order 26.4b1 On NJ ex order 26.4b1, Resident #2 NJ ex order 26.4b1 The facility failed to prodive documented evidence that Resident #2 had been reassessed by an RN upon his/her return from	A 765		

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A 765	Continued From page 2 NJ ex order 26.4b1 . The facility failed to provide a RN assessment of Resident #2 in order to determine if further medical treatment, NJ Exec O management of nursing interventions were necessary.	A 765		

Harmony Village at CareOne Stanwick Road Memory Care Community
NJ License # 03A004
Complaint Survey 8-22-23

Plan of Correction

ID Prefix Tag: A 765

A. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
   a. Resident #2's medical records was reviewed, and the registered nurse completed a [redacted] NJ Ex Order 26.4b1

B. How the facility will identify other residents having the potential to be affected by the same deficient practice.
   a. Residents residing in the center have the potential to be affected.

C. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.
   a. The Director of Nursing or Designee will in-service the licensed staff on the need for an RN assessment upon a resident's admission, and return to the facility for re-admission from the hospital, and with change in condition.

   b. The Director of Nursing or designee will communicate residents' change in condition with the physician to determine if further medical treatment including pain management is necessary.

D. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what QA program will be put into place to monitor the continued effectiveness of the systemic change.
   a. The Director of Nursing, Administrator or RN Designee will review weekly the Incident Management System for 4 weeks, and those residents acutely transferred to ensure they are assessed by an RN and medicated for pain as needed and upon return to the facility for re-admission with change in condition. After the 4 week audit, review will continue on a monthly.

   b. The results of the weekly audit will be presented to the Administrator and the Quality Assurance Performance Improvement Committee monthly x3 months. The QA Committee will determine the need for further performance improvement.

Completed 8/24/23 and ongoing .

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
03A004	A. Building B. Wing	11/6/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY VILLAGE AT CAREONE STANWICK ROAD	301 N STANWICK ROAD MOORESTOWN, NJ 08057

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0765 Reg. # 8:36-7.4(c)(1) LSC	Correction Completed 08/24/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
8/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO